DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 — 009

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Not Required

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 13, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1932.a

7. FEDERAL BUDGET IMPACT:
a. FFY 8/01/03-9/30/03 $ $5,037,947,088.00
b. FFY 10/01/03-9/30/04 $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Medi-Cal Managed Care Enrollment 3.7 pp 31e-31p
~~Attachments: 3.7, P.1 and 3.7B, P.1~~
Attachment 3.7A pp 1-11
Attachment 3.7B pp 1-9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Table of Contents
~~N/A~~ page iii (of TN 87-08)
List of Eppage 3 (of TN 92-09)
Attach. Epage 4 (of TN 92-09)

10. SUBJECT OF AMENDMENT:
Medi-Cal Managed Care Enrollment

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stan Rosenstein

14. TITLE:
Deputy Director

15. DATE SUBMITTED:

16. RETURN TO:
California Department of Health Services
1501 Capitol Avenue, MS 4000
P.O. Box 942732
Sacramento, CA 94234-7320

Attn: State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: January 8, 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 13, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Linda Minamoto

22. TITLE:
Associate Regional Administrator

23. REMARKS:
Pen and ink change to #9 above as agreed to in 1/6/04 email. SR
Pen and ink change to #8 above as agreed to in 1/7 email. SR

FORM HCFA-179 (07-92)

Instructions on Back

SECTION PAGE NUMBERS

No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services provided to the Categorically Needy
	* Supplement 1-- Case Management Services Supplement 2-- Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
3.1-F	Community Supported Living Arrangements Services Provided to the Developmentally Disabled
3.2-A	Coordination of Title XIX with Part B of Title XVIII
3.7-A	Medi-Cal Managed Care/Two Plan Model
3.7-B	Medi-Cal Managed Care/Geographic Managed Care Model
4.4-A	California MMIS Alternative Claims Processing Assessment System
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutional Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy – Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups

*Forms Provided

No.	Title of Attachment
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care
4.19-B	Methods and Standards for Establishing Payment Rates – Other Types of Care
	• Supplement 1 – Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates – Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claim Payment – Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability—Identifying Liable Resources
*4-22-B	Requirements for Third Party Liability—Payment of Claims
*4.22-C	Cost –Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
4.34-A	Requirements for Advance Directives Under State Plans for Medical Assistance
4.35-A	Criteria for the Application of Specified Remedies for SNFs
4.35-B	Alternative Remedies to Specified Remedies for SNFs
5.3-A	Training Programs; Subprofessional and Volunteer Programs
7.2-A	Methods of Administration – Civil Rights (Title VI)
7.2-B	Methods of Administration – Section 504 Rehabilitation Act

*Forms Provided

Citation	Condition or Requirement

1932 (a)(1)(A)

A. 3.7 - Section 1932 (a)(1)(A) – Mandatory Managed Care Enrollment.

The State of California enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (i.e. managed care organization (MCOs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.240). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plan (PIHP), or to mandate the enrollment of Medicaid beneficiaries who are Medicaid eligible, who are Indians (unless they would be enrolled in certain plans—see D.ii below), or who meet eligible certain categories of "special needs" beneficiaries (see D.iii-vii.)

B. General Description of the Program and Public Process.

1932 (a)(1)(B)(i)
1932 (a)(1)(B)(ii)

1. Describe the contracting entities by indicating if they are an MCO or PCCM.

This program is called Medi-Cal Managed Care (MMC). The program is being implemented in select counties and zip codes throughout California. All Medicaid beneficiaries, depending on the beneficiaries' geographic location, and Medi-Cal eligibility-related aid code, as describe in Section D, are required to enroll in a managed care organization (MCO) program. Those Medicaid beneficiaries as described in Section G, are not subject to mandatory enrollment, but are permitted to voluntarily enroll in a managed care organization (MCO) program. Regardless of model, all MCOs are risk-comprehensive contracts.

42 CFR 438.50 (b)(1)
CFR 438.50 (b)(2)
CFR 438.50 (b)(3)

2. Discuss the payment method to be utilized (i.e. fee for service, capitation, case management fee, bonus/incentive and/or supplemental payments).

Each MCO is paid a monthly capitation payment for each beneficiary who is Medi-Cal eligible and enrolled in that plan.

Citation	Condition or Requirement

CFR 438.50 (b)(4)

3. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.

The various models have been operational as follows: Sacramento Geographic Managed Care as of 4/1/94, Two-Plan Model as of 1/22/96, and Healthy San Diego Geographic Managed Care as of 10/16/98. Therefore, there will be no new design and implementation process used for this SPA.

On an ongoing basis, the Department of Health Services (DHS) employs many methods to insure public involvement:

- **<u>The Medi-Cal Managed Care Advisory Group:</u> The California Department of Health Services (DHS) Medi-Cal Managed Care Division (MMCD) Advisory Group was formed in December 1998, as a vehicle to facilitate active communication between the Medi-Cal Managed Care Program, and all interested parties and stakeholders.**

  The MMCD Advisory Group membership consists of advocacy groups, health plan representatives, medical associations, and the State's enrollment broker. The Advisory Group meetings are held in Sacramento and are chaired by the MMCD Chief. The Group is routinely advised about issues relevant to Medi-Cal managed care, and is often solicited for feedback on issues such as informing materials and the State Quality Strategy.

- **Prior to the submission of this state plan amendment and for any future changes, Tribal input is being/will be solicited by direct inquiry to tribal councils and the California Rural Indian Health Board (CRIHB).**

- **Prior to the implementation of this state plan amendment and any future modifications, public input is being/will be solicited through published news articles produced by DHS's Public Information Office.**

1932 (a)(1)(A)

4. Affirm if the state plan program will implement mandatory enrollment into managed care on a statewide basis. If not, identify the county/areas where mandatory enrollment will be implemented.

The different models of managed care, and their respective locations, are described in detail in Attachments 3.7-A and 3.7-B.

Citation	Condition or Requirement

C. State Assurances and Compliance with the Statute and Regulations.

The state assures all the applicable requirements that include but are not limited to the following statute and regulations are met:

1932 (a)(1)(A)(i)(I) 1903 (m) 438.50 (c)(1)	1. Section 1903 (m) of the Act, for MCOs and MCO contracts.
1932 (a)(1)(A)(i)(I) 1905 (t) 42 CFR 438.50 (c)(2) 1902 (a)(23)(A)	2. Section 1905 (t) of the Act for PCCMs and PCCM contracts. **N/A**
1932 (a)(1)(A) 42 CFR 438.50 (c)(3)	3. Section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.
1932 (a)(1)(A) 42 CFR 431.51	4. 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C).
1932 (a)(1)(A) 42 CFR 438 42 CFR 438.50 (c)(4) 1903 (m)	5. 42 CFR 438 for MCOs.
1932 (a)(1)(A) 42 CFR 438.6 (c) 42 CFR 438.50 (c)(6)	6. 42 CFR 438.6 (c) for payments under any risk contracts.
1932 (a)(1)(A) 42 CFR 447.362 42 CFR 438.50 (c)(6)	7. 42 CFR 447.362 for payments under any nonrisk contracts. **N/A**
45 CFR 74.40	8. 45 CFR 74.40 for procurement of contracts.

Citation	Condition or Requirement

D. Eligible groups

1932 (a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.
Title XIX of the Social Security Act applicable Sections:

A. 1925
B. 1905 (u) (2)
C. 1931
D. 1902(a)(10)(A)(i)(III)
E. 1902(a)(10)(A)(i)(IV)
F. 1902(a)(10)(A)(i)(VI)
G. 1902(a)(10)(A)(i)(VII)

Enrollment will be mandatory for beneficiaries who meet the criteria and are not ineligible to participate because they fail to meet any of the following additional criteria listed in (a) through (c) of this section:

(a) Are eligible to receive Medi-Cal services that are not limited in scope. If services are limited in scope, the beneficiary is not eligible to enroll. Limited scope means a subset of the scope of benefits as described in the state plan with or without a share-of-cost.
(b) Have been determined to have a share of cost equal to zero. If the share of cost is greater than zero, the beneficiary is not eligible to enroll.
(c) Have been found by their county welfare department to be eligible under one of the following programs and do not qualify for an exemption to mandatory enrollment.

2. Mandatory exempt groups

Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.

1932 (a)(2)(B)
42 CFR 438 (d)(1)

i. Recipients who are also eligible for Medicare

__X__ The state will allow these individuals to voluntarily enroll in the managed care program.

In the case of a beneficiary who is in a mandatory aid code whose eligbility is subsequently changed to a voluntary aid code, the individual would be allowed to exercise their right to disenroll from a managed care plan. Individuals are informed of their rights by the enrollment broker at the time they become eligible for Medicare.

Citation	Condition or Requirement

1932 (a)(2)(C)
42 CFR 438 (d)(2)

ii. Indians who are members of Federally recognized tribes, unless the MCO or PCCM is the Indian Health Service; an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service; or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service.

_X_ The state will allow these individuals to voluntarily enroll in the managed care program.

Members of Federally recognized tribes, Native American Indians, Alaskan Native, or qualified non-Indian (means an immediate family member) or a non-Indian who has been verified by the Indian Health Service Center as receiving services there, may choose to disenroll and receive health care services from an Indian Health Service Center. Alternatively, American Indians and Alaskan Natives may choose to enroll on a voluntary basis.

1932 (a)(2)(A)(i)
42 CFR 438.50 (d)(3)(i)

iii. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

_X_ The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(iii)
42 CFR 438.50 (d)(3)(ii)

iv. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

____ The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(v)
42 CFR 438.50 (3)(iii)

v. Children under the age of 19 years who are in foster care or other out-of-the-home placement.

_X_ The state will allow these individuals to voluntarily enroll in the managed care program.

Also, for children who cannot be immediately identified as foster care by Medi-Cal's unique identifier, upon obtaining concurrence of the

Citation	Condition or Requirement

child's caretaker, a county director of social services, or his/her designee in one of the designated counties, or the Probation Officer in case of a foster child who is a ward of the court, a foster child may be enrolled voluntarily into an available managed care plan. Similarly, an adoptive parent may voluntarily enroll an AAP child into an available managed care plan.

1932 (a)(2)(A)(iv)
42 CFR 438.50 (3)(iv)

vi. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

_X__ The state will allow these individuals to voluntarily enroll in the managed care program.

See also comment in v. above.

1932 (a)(2)(A)(ii);
42 CFR 438.50 (3)(v)

vii. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

___ The state will allow these individuals to voluntarily enroll in the managed care program.

Children receiving services through the California Children's Services (CCS) program in geographic areas served by either the Two-Plan, San Diego GMC, or Sacramento GMC models of managed care will be mandatorily enrolled into these MCOs under a separate Section 1915(b) waiver.

E. Identification of Mandatory Exempt Groups

1932 (a)(2)
42 CFR 438.50 (d)

1. How does the state define children who receive services funded under section 501 (a)(1)(D) of title V?

The State's definition includes all children receiving services through the California Children's Services (CCS) program.

Although, children receiving services through the California Children's Services (CCS) program in geographic areas served by either the Two-Plan, San Diego GMC, or Sacramento GMC models of managed care will

Citation	Condition or Requirement

be mandatorily enrolled into these MCOs under a separate Section 1915(b) waiver, identification of this population is possible by:

- **A Medi-Cal unique identifier on the eligibility file**
- **CMS Net – an automated case management system that includes CCS programs' demographic data, or**
- **For those counties not on CMS Net, a manual report is prepared by the county and distributed to each managed care plan the recipient is enrolled in.**

1932 (a)(2)
42 CFR 438.50 (d)

2. Is the state's definition of these children in terms of program participation or special health care needs?

The definition is driven by CCS program participation.

1932 (a)(2)
42 CFR 438.50 (d)

3. Does the scope of these title V services include services received through a family-centered, community-based, coordinated care system?

Yes

1932(a)(2)
42 CFR 438.50 (d)

4. How does the state identify the following groups of children who are exempt from mandatory enrollment:

i. Children under 19 years of age who are eligible for SSI under title XVI;

By Medi-Cal or other unique identifier or by self identification.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Not applicable

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

By Medi-Cal or other unique identifier or by self identification

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

By Medi-Cal or other unique identifier or by self identification.

Citation	Condition or Requirement

1932(a)(2)

5. What is the state's process for allowing children to request an exemption based on 42 CFR 438.50 (d) the special needs criteria as defined in the state plan if they are not initially identified as exempt from mandatory enrollment?

Children not otherwise identified by unique identifiers are allowed to self-identify to the State and be exempt from mandatory enrollment.

1932 (a)(2)
42 CFR 438.50 (d)

6. How does the state identify the following groups who are exempt from mandatory enrollment into managed care:

i. Recipients who are also eligible for Medicare.

There is a unique Other Health Coverage Code on the MEDS record.

ii. Indians who are members of Federally recognized tribes, unless the MCO or PCCM is the Indian Health Service; an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service; or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service.

By self identification

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

The following populations may be excluded from mandatory enrollment upon filing an exemption form with the State's Health Care Options (HCO) contractor, and receiving services through the traditional FFS:

Non-Medical:
Enrolled in a waiver for skilled nursing services in their home.

Medical:
Beneficiaries being treated for a complex condition from a physician who is participating in the Medi-Cal program, but is not a contract provider of the managed care plans in the service area, may request exclusion from mandatory enrollment upon filing an exemption form with the State's Health Care

Citation	Condition or Requirement

Options (HCO) contractor and receiving services through the traditional FFS. Complex conditions include:

Pregnancy;
Cancer;
Organ transplant (except Kidney) – or are scheduled for one;
Renal disease and have dialysis at least two times a week;
A disease that affects more than one organ system (such as diabetes);
HIV positive;
A neurological disorder (such as multiple sclerosis); and
Other conditions as determined by the State.

The following populations are excluded from enrollment in an MCO under this state plan:

(1) Members of a commercial health plan through private insurance that is identified as "other health coverage" at the time of initial enrollment eligibility. If an individual acquires other health coverage after enrollment in a Plan, the State will allow the member to remain enrolled on a voluntary basis in the plan.
(2) If another health coverage code indicates Medicare coverage and is on the beneficiaries' eligibility file record prior to enrollment, that beneficiary will be excluded from enrollment unless the beneficiary enrolls in a Medicaid managed care plan that is also a Medicare +Choice managed care plan. However, for the purpose of continuity of care, if someone with Medicare coverage is identified only after enrollment into Medicaid managed care, instead of disenrolling and being returned to fee-for-service program, those individuals may remain enrolled on a voluntary basis;
(3) Individuals eligible for Medicaid after paying a share of cost;
(4) Individuals already residing in a Long Term Care (LTC) (includes: nursing facility, sub-acute, pediatric, and Intermediate care facilities) facility at the time Medicaid is approved;
(5) Individuals who have an eligibility period that is less than 3 months;
(6) Individuals who have an eligibility period that is only retroactive;
(7) Individuals eligible for Limited Services (See page 31 h) and
(8) Individuals enrolled in a Model Home and Community Based Waiver.

Citation	Condition or Requirement

42 CFR 438.50

G. List all other eligible groups that will be permitted to enroll on a voluntary basis

Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria as described in section 2 of the California State Plan, including related attachments and supplements:

(1) Are eligible to receive services that are not limited in scope.

(2) Have been determined to have a share of cost equal to zero; and

(3) Have been determined by their county welfare department to be eligible for one of the following programs:

Title XIX of the Social Security Act applicable Sections:

A. 1902(a)(10)(A)(ii)(XVIII)
B. 1902(a)(10)(A)(i)(I)
C. 1902(a)(10)(C)
D. 1902(a)(10)(A)(ii)(X)
E. 1902(a)(10)(A)(i)(II)
F. 1902(a)(10)(A)(ii)(XV)
G. 1634

(4) Beneficiaries enrolled in one of the following forms of other health coverage, obtained after enrollment in a Medi-Cal managed care plan, shall be allowed to remain enrolled:

(A) Medicare HMO,
(B) CHAMPUS Prime HMO,
(C) Kaiser HMO, or
(D) Any other HMO, or prepaid health plan in which the enrollee is limited to a prescribed panel of providers for comprehensive services.

H. Enrollment process.

1932 (a)(4)
42 CFR 438.50

1. Definitions

i. An **existing provider-recipient relationship** is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have **"traditionally served"** Medicaid recipients if it has experience in serving the Medicaid population.

Citation	Condition or Requirement

1932 (a)(4)
42 CFR 438.50

2. State process for enrollment by default.
Describe how the state's default enrollment process will preserve **(See Attachments 3.7-A and B for a description by model):**

:

i. the existing provider-recipient relationship;

ii. the relationship with providers that have traditionally served Medicaid recipients;

iii. the equitable distribution of Medicaid recipients among qualified MCOs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).

1932 (a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following items **(See Attachments 3.7-A and B for a description by model):**

i. Indicate if the state will use a lock-in for managed care managed care.

ii. Give the time frame for recipients to choose a health plan before being auto-assigned.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment.

v. Describe the default assignment algorithm used for auto-assignment.

vi. Describe how the state will monitor any changes in the rate of default assignment.

1932 (a)(4)
42 CFR 438.50

I. <u>State assurances on the enrollment process</u>

1. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO does not have capacity to accept all who are seeking enrollment under the program.

Citation	Condition or Requirement

2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in an MCO model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52 (b)(3).

____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (If applicable, place check mark to indicate state's affirmation.)

3. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) **(Not applicable to this SPA).**

_____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56 (g) if recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. (If applicable, place check mark to indicate state's affirmation.)

1932 (a)(4)

J. Disenrollment

42 CFR 438.50

1. Affirm if the state uses lock-in for managed care and identify how many months (up to 12 months) will the lock-in apply. **N/A**

2. The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).

3. What are the additional circumstances of "cause" for disenrollment? (If any.)

The State does not limit disenrollment (i.e., the enrollees may switch plans at any time).

K. Information requirements for beneficiaries

1932 (a)(5)
42 CFR 438.50
42 CFR 438.10

The state assures that its state plan program is in compliance with 42 CFR 438.10 (i) for information requirements specific to MCOs programs operated under section 1932 (a)(1)(A)(i) state plan amendments.

1932 (a)(5)(D)

L. Description of excluded services for each model (MCO & PCCM)

See Attachments 3.7-A and B for description by model

STATE: CALIFORNIA

MANDATORY MANAGED CARE ENROLLMENT

MEDI-CAL MANAGED CARE/TWO PLAN MODEL

1. This program will be available in the following counties:

- **Los Angeles, except (**see list of excluded zip codes)**
- **Kern, except (**see list of excluded zip codes)**
- **San Bernardino, except (***see list of excluded zip codes)**
- **Riverside, except (**see list of excluded zip codes)**
- **Tulare**
- **Fresno**
- **Santa Clara**
- **Stanislaus**
- **San Joaquin**
- **San Francisco**
- **Alameda**
- **Contra Costa**

EXCLUDED ZIP CODES

***Kern County---93555 and 93556 Ridgecrest.**

****The Los Angeles Region includes Los Angeles County with the exclusion of the following ZIP code, which covers Santa Catalina: --90704.**

*****The San Bernardino/Riverside Region includes San Bernardino County, and Riverside County with the exclusion of the following rural ZIP codes in these counties:**

EXCLUDED MEDI-CAL ZIP CODES IN RIVERSIDE AND SAN BERNARDINO COUNTIES		
ZIP CODE	PREFERRED CITY NAME	COUNTY
92225	Blythe	Riverside
92226	Blythe	Riverside
92239	Desert Center	Riverside
92280	Vidal	Riverside & San Bernardino
92242	Earp	San Bernardino
92252	Joshua Tree	San Bernardino
92256	Morongo Valley	San Bernardino
92267	Parker Dam	San Bernardino

STATE: CALIFORNIA

MANDATORY MANAGED CARE ENROLLMENT

MEDI-CAL MANAGED CARE/TWO PLAN MODEL

92268	Pioneer Town	San Bernardino
92277	Twenty-nine Palms	San Bernardino
92278	Marine Base Corps	San Bernardino
92284	Yucca Valley	San Bernardino
92285	Landers	San Bernardino
92286	Yucca Valley	San Bernardino
92304	Amboy/Cadiz	San Bernardino
92305	Angelus Oaks	San Bernardino
92309	Baker	San Bernardino
92310	Fort Irwin	San Bernardino
92311	Lenwood/Barstow	San Bernardino
92312	Barstow	San Bernardino
92314	Big Bear City	San Bernardino
92315	Big Bear Lake	San Bernardino
92317	Blue Jay	San Bernardino
92319	Cadiz	San Bernardino
92321	Cedar Glen	San Bernardino
92322	Cedarpines Park	San Bernardino
92323	Cima	San Bernardino
92325	Crestline	San Bernardino
92326	Crest Park	San Bernardino
92327	Daggett	San Bernardino
92332	Essex	San Bernardino
92333	Fawnskin	San Bernardino
92338	Ludlow (Newberry Springs)	San Bernardino
92339	Forest Falls	San Bernardino
92341	Green Valley Lake	San Bernardino
92342	Helendale	San Bernardino
92347	Hinkley	San Bernardino
92352	Lake Arrowhead	San Bernardino
92356	Lucerne Valley	San Bernardino
92358	Lytle Creek	San Bernardino
92363	Needles	San Bernardino
92364	Nipton	San Bernardino
92365	Newberry Springs	San Bernardino
92366	Mountain Pass	San Bernardino
92368	Oro Grande	San Bernardino
92372	Pinon Hills	San Bernardino

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92378	Rimforest	San Bernardino
92397	Wrightwood	San Bernardino
92382	Running Springs	San Bernardino
92385	Skyforest	San Bernardino
92386	Sugarloaf	San Bernardino
92391	Twin Peaks	San Bernardino
92398	Yermo	San Bernardino
93528	Johannsburg	San Bernardino
93554	Johannsburg	San Bernardino
93558	Red Mountain	San Bernardino
93562	Trona	San Bernardino
93592	Trona	San Bernardino
92267	Parker Dam	San Bernardino

2. The State will contract with two MCOs in each county to provide services, and beneficiaries will have a choice between these two plans* (See exception below for Stanislaus County).

   In general, the State will contract with one MCO, referred to as the Local Initiative (LI) health plan and one MCO, referred to as the Commercial Plan (CP). The LI is a locally developed comprehensive managed care system, developed under the leadership of the County Board of Supervisors. It is essentially a public-private partnership that will have a contractual obligation to include traditional and safety net providers in its network. If there is no Local Initiative in a particular county, the State will then seek to contract with two Commercial Plans.

   In Stanislaus County, FFS will remain an option for all individuals who would otherwise be mandatorily enrolled in managed care until the Spring, 2004, when the State expects to have in effect a contract with a second managed care plan.

3. Use of an enrollment broker

   A. Process

   The State's Health Care Option (HCO) broker will conduct enrollment sessions in each County with all Medicaid eligible beneficiaries that voluntarily chose to attend. Beneficiaries are informed of these sites

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through the presentation schedule included in the enrollment packets. Referrals are also made by eligibility workers, the enrollment broker's call center staff, and by word of mouth.

The State assures the information will be presented to non-English speaking participants in a culturally competent manner. Accommodations for the visually and hearing impaired, and the physically disabled are made available.

B. Content

The content of the enrollment sessions includes information as follows:

1. **Description of what is a Medi-Cal health plan (MCO);**
2. **Who must vs. who may join a MCO;**
3. **Who are not eligible to join a MCO;**
4. **Who may be exempt from mandatory participation in a MCO;**
5. **Service and items covered by the MCO;**
6. **Benefits outside the managed care contract, and how participants may access these services;**
7. **How to change PCPs, or MCOs;**
8. **Grievance and appeal rights provided by the MCOs and the State Fair Hearing process, and the procedures for using them.**

C. Enrollment Packets

The population subject to the initial process includes those Medi-Cal beneficiaries in mandatory aid code who are eligible for enrollment in a managed care plan.

Beneficiaries who are newly eligible for enrollment in a mandatory aid code managed care plan are mailed an Intent to Assign (IA) Packet. The IA process is as follows:

- **The Enrollment Broker receives the newly eligible list and an IA record is generated.**
- **The IA records are sent and received by the Enrollment Broker Mail house which has three days to process them.**

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- **The HCO Contractor prepares the IA packet and mails it to the newly eligible. Five days are allowed for mail time.**
- **The newly eligible has 30 days to decide on a plan and respond with his/ her decision.**
- **When the newly eligible's response is received, a transaction is processed and he/ she is enrolled in the plan. The enrollment packet contains the directive that eligible beneficiaries may change plans at any time after this selection.**

Annual Renotification Process:

Managed Care enrollees are again informed of their right to change health plans at any time during the Annual Renotification process. This process includes sending a notice to each enrollee that has been in the same plan for ten consecutive months. The notice includes a "tear off" postcard that can be mailed back requesting materials for changing health plans.

Should a beneficiary request disenrollment from their current plan during the renotification process or at any other time, the request will be processed no later than the end of the month following the month in which the request to disenroll is received by the enrollment contractor.

1. Default Enrollment

   Medicaid recipients who are subject to mandatory enrollment, but fail to make a choice within 30 days of receiving an enrollment packet, shall be automatically enrolled (defaulted) into a MCO as follows:

   - **If no response is received within 13 days of the mailing of the enrollment packet, an Intent to Default (ID) letter is mailed.**
     - **The ID letter will address:**
       a) **a reminder that unless the eligible responded to the IA packet, he/she will be assigned to a MCO by default, and**
       b) **reiterates the date in which he/she must respond by in order to preclude assignment.**
   - **If still no response is received, a default transaction is created and sent to MEDS.**

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- **Then a confirmation letter is generated and mailed to the beneficiary informing them of the name of the plan assigned and the effective date of the assignment.**

The beneficiary may choose to change plans at any time after receiving the official default notification from the enrollment broker. If the beneficiary decides to change plans, the beneficiary may call the enrollment broker's toll-free telephone number for additional assistance.

Enrollment will be based upon maintaining prior family-plan relationship, or where not possible, an equitable distribution among MCOs. The State will use a central enrollment broker, and the criteria for assigned enrollment is described below.

When a beneficiary is assigned to a plan, a weighted assignment method shall be used to determine the plan to be assigned. Considerations that apply include, but are not limited to, the following:

a. **A beneficiary shall only be assigned to a managed care plan with a primary care service site in the same ZIP code as the beneficiary's residence;**

b. **A beneficiary shall be assigned to the same managed care plan as:**
    1) **that in which he/she was previously enrolled;**
    2) **that in which a head of household (case head) is enrolled; and**
    3) **if the case head is not enrolled in a plan, then that in which another family member is enrolled.**

However, provided at least one family member has maintained managed care assignment history, and in order to preserve continuity of care, the following considerations shall be taken for each assignment:

- **Continuity of care is maintained at a case/household level;**
- **At least one member of the household must remain continuously eligible within the county for continuity of care to be assigned to someone within that case;**

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- **If a member of the case loses eligibility for more than 120 days, the case history is archived; however, should the member re-establish eligibility, continuity of care would be restored based on the case;**
- **If all members of the case lose eligibility for more than 120 days, the case is archived, and continuity of care is lost; and**
- **If the entire case moves out of the county of eligibility, continuity of care is lost.**

c. A beneficiary shall be assigned to a managed care plan when he/she is eligible to enroll. This includes:

1) **A managed care plan that has the capacity to accept new patients;**
2) **A managed care plan that provides services to those persons in the aid code of the applicant;**
3) **A managed care plan that has language capability to meet the beneficiaries needs; and**
4) **An available PCP provider who is within a ten-mile radius of the beneficiary's residence.**

d. HCO shall adhere to the State's algorithm of 1:1 for assignment of beneficiaries to the various managed care plans in each county, pursuant to State regulations (California Code of Regulations, Title 22, Section 53820), and written directives.

A description of the current minimum/maximum (min/max) calculations is a follows:

The calculation of the min/max numbers comprises two parts, the calculation of the Disproportionate Share Hospital factor for each county, and the calculation of the number of eligible beneficiaries.

Effective August 12, 2002, when a LI reaches 103% of their minimum, default assignments will be made on a 1:1 basis. Currently, some counties are already on a 1:1 basis, because of agreements between the health plans, which are approved by DHS.

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Specifically, the assignment calculation preserves the relationship with providers that have traditionally served Medicaid (i.e., the LIs).

5. Monitoring Default Rates:

The default rates are monitored through a reporting process. The HCO Section receives daily, weekly and monthly reports from the enrollment broker that are required for monitoring the default process. The reports are as follows:

- **Review the Daily Status Report- provides a breakout of enrollment into the local initiative and the commercial plans in each Managed Care county and the default ratios for each county.**
- **Review the Monthly Managed Care Maximum Enrollment Report – provides information on the maximum and minimum beneficiary enrollment capitations of all local initiatives and commercial managed care plans.**
- **Review the Monthly Enrollment Default Percentages Report – provides county specific default percentages for all managed care counties.**
- **Review the MSC-B-M02 Monthly Enrollment summary – provides formula determined default percentage rates for the 2-Plan and GMC.**
- **Review the Monthly Progress Report – provides summary for the MSM-B-M22 Monthly Cumulative Medical Beneficiaries Assigned to Local Initiative and Commercial Plans.**
- **Random sampling of the processed enrollment forms.**

The default rates are monitored daily and determined on a monthly basis for plan accuracy. If the Local Initiative is below the minimum number, the monitoring process ensures that the LI is getting all defaults.

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6. Covered Services

All services included in the approved California Medicaid state plan are provided by the MCOs under this State Plan Amendment, with the following exceptions:

A. Services for major organ transplant procedures that are Medi-Cal benefits (except for kidney transplant).

B. Long Term care services in a facility for longer than the month of admission plus one month.

C. Home and Community Based Services (HCBS) Waiver Programs authorized under section 1915 (c) of the Social Security Act, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver.

D. Services authorized by the California Children Services (CCS) program.

E. Mental health services which are outside the scope of PCPs.

F. Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider.

G. Alcohol and drug treatment services and outpatient heroin detoxification.

H. Fabrication of optical lenses provided through Prison Industry Authority optical laboratories.

I. Directly observed therapy for treatment of tuberculosis provided by local health departments.

J. Dental services as specified in CCR, Title 22, Section 51307 and EPSDT supplemental dental services as described in CCR, Title 22, Section 51340.1(a). However, Contractor is responsible for all Covered Services that are within the scope of the PCP regarding dental services.

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K. Acupuncture services as specified in CCR, Title 22, Section 51308.5.

L. Chiropractic services as specified in CCR, Title 22, Section 51308.

M. Prayer or spiritual healing as specified in CCR, Title 22, Section 51312.

N. Local Education Agency (LEA) assessment services as specified in CCR, Title 22, Section 51360(b)(1) provided to a member who qualifies for LEA services based on CCR, Title 22, Section 51190.1(a).

O. Any LEA services as specified in CCR, Title 22, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq., or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in CCR, Title 22, Section 51360.

P. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHS.

Q. Adult Day Health Care.

R. Pediatric Day Health Care.

S. Personal Care Services.

T. State supported Services.

U. Targeted case management services as specified in CCR, Title 22, Sections 51185(h) and 51351. Except that the MCO shall be responsible for: 1) coordinating health care with the TCM provider and for determining medical necessity of diagnostic and treatment services recommended by the TCM provider, and 2) ensuring access to services comparable to EPSDT TCM services for those members under age 21 who are not accepted for TCM services.

V. Childhood lead poisoning case management provided by County health departments.

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W. Specific Psychotherapeutic drugs and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997.

X. Specific Human Immunodeficiency Virus (HIV) and AIDS drugs and HIV/AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, and any future category of drugs for the treatment of HIV and AIDS, not previously classified (i.e. Fusion Inhibitors) approved by the federal Food and Drug Administration (FDA) after July 1, 1997. Effective May 1, 2004, these drugs will be carved back into the covered services for each plan.

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1. This program will be available in **Sacramento** and **San Diego** Counties, with the exception of the following zip codes: **None**

2. The State will contract with multiple MCOs to provide services and beneficiaries will have a choice of no less than two plans.

3. Use of an enrollment broker.

   A. Process

   The State's Health Care Option (HCO) broker will conduct in-person enrollment sessions with all Medicaid eligibles in Sacramento County that voluntarily chose to attend.

   In San Diego County, county employees will conduct in-person enrollment sessions with all Medicaid eligibles that voluntarily choose to attend.

   Beneficiaries are informed of these sites through the presentation schedule included in the enrollment packets. Referrals are also made by eligibility workers, the enrollment broker's call center staff, and by word of mouth.

   The State assures the information will be presented to non-English speaking participants in a culturally competent manner. Accommodations for the visually and hearing impaired and the physically disabled are made available.

   B. Content

   The content of the enrollment sessions includes, information as follows:

   1. **Description of what is a Medi-Cal health plan (MCO);**
   2. **Who must vs. who may join a MCO;**
   3. **Who is not eligible to join a MCO;**
   4. **Who may be exempt from mandatory participation in a MCO;**

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5. **Service and items covered by the MCO;**
6. **Benefits outside the managed care contract, and how participants may access these services;**
7. **How to change PCPs, or MCOs;**
8. **Grievance and appeal rights provided by the MCOs and the State Fair Hearing process, and the procedures for using them.**

C. Enrollment Packets

The population subject to the initial process includes those Medi-Cal beneficiaries in mandatory aid code who are eligible for enrollment in a managed care plan.

Beneficiaries who are newly eligible for enrollment in a mandatory aid code managed care plan are mailed an Intent to Assign (IA) Packet. The IA process is as follows:

- **The Enrollment Broker receives the newly eligible list and an IA record is generated.**
- **The IA records are sent and received by the Enrollment Broker Mail house which has three days to process them.**
- **The HCO Contractor prepares the IA packet and mails it to the newly eligible. Five days are allowed for mail time.**
- **The newly eligible has 30 days to decide on a plan and respond with his/her decision.**
- **When the newly eligible's response is received, a transaction is processed and he/she is enrolled in the plan. The enrollment packet contains the directive that eligible beneficiaries may change plans at any time after this selection.**

Annual Renotification Process:

Managed Care enrollees are again informed of their right to change health plans at any time during the Annual Renotification process. This process includes sending a notice to each enrollee that has been in the same plan for ten consecutive months. The notice includes a "tear off" postcard that can be mailed back requesting materials for changing health plans.

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Should a beneficiary request disenrollment from their current plan during the renotification process or at any other time, the request will be processed no later than the end of the month following the month in which the request to disenroll is received by the enrollment contractor.

4. Default Enrollment:

Medicaid recipients who are subject to mandatory enrollment, but fail to make a choice within 30 days of receiving an enrollment packet, shall be automatically enrolled (defaulted) in a MCO as follows:

- **If no response is received within 13 days of the mailing of the enrollment packet, an Intent to Default (ID) letter is mailed.**
  - **The default letter will address:**
    - **a) a reminder that unless the eligible responds to the IA packet, he/she will be assigned to a MCO by default, and b) the effective date of assignment, and**
    - **b) reiterates the date in which he/she must respond by in order to preclude assignment.**
- **If still no response is received, a default transaction is created and sent to MEDS.**
- **Then a confirmation letter is generated and mailed to the beneficiary informing them of the name of the plan assigned and the effective date of the assignment.**

The beneficiary may choose to change plans at any time after receiving the official default notification from the enrollment broker. If the beneficiary decides to change plans, the beneficiary may call the enrollment broker's toll-free telephone number for additional assistance.

Enrollment will be based on maintaining prior family-plan relationship, or where not possible, an equitable distribution among MCOs. The State will use a central enrollment broker, and the criteria for assigned enrollment is described below.

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When a beneficiary is assigned to a plan, a weighted assignment method shall be used to determine the plan assigned. Considerations that apply include, but are not limited to, the following:

a. **A beneficiary shall only be assigned to a managed care plan with a primary care service site in the same ZIP code as the beneficiary's residence;**

b. **A beneficiary shall be assigned to the same managed care plan as:**

   1) **that in which he/she was previously enrolled;**
   2) **that in which a head-of-household (case head) is enrolled; and**
   3) **if the case head is not enrolled in a plan, then that in which another family member is enrolled.**

However, provided at least one family member has maintained managed care assignment history, and in order to preserve continuity of care, the following considerations shall be taken for each assignment:

- **Continuity of care is maintained at a case/household level;**
- **At least one member of the household must remain continuously eligible within the county for continuity of care to be assigned to someone within that case;**
- **If a member of the case loses eligibility for more than 120 days, the case history is archived; however, should the member re-establish eligibility, continuity of care would be restored based on the case;**
- **If all members of the case lose eligibility for more than 120 days, the case is archived and continuity of care is lost; and**
- **If the entire case moves out of the county of eligibility, continuity of care is lost.**

c. **A beneficiary shall be assigned to a managed care plan when he/she is eligible to enroll. This includes:**

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1) **A managed care plan that has the capacity to accept new patients;**
2) **A managed care plan that provides services to those persons in the aid code of the applicant;**
3) **A managed care plan that has language capability to meet the beneficiaries needs; and**
4) **An available PCP provider who is within a ten-mile radius of the beneficiary's residence.**

d. **HCO shall adhere to the State's methodology for equitable assignment of beneficiaries to the various managed care plans in each county, pursuant to State regulations (California Code of Regulations, Title 22, Section 53922), and written directives.**

A description of the current methodology is as follows:

The GMC enrolment contractor shall implement a system approved by the department to assign an eligible beneficiary described in Section 53906(a), to GMC plans, in the event the beneficiary does not select GMC plans pursuant to Section 53921(d).

The Assignment shall ensure the equitable distribution of eligible beneficiaries among GMC plans and include but not be limited to the following considerations:

- **Zip code of eligible beneficiary matched to zip codes served by the GMC plan.**
- **Enrollment capacity and availability of the GMC plan.**
- **GMC plan's ability to render linguistically appropriate services and the eligible beneficiary's need for those services, if made known to the GMC enrollment contractor.**
- **Rotation of assignment among all GMC plans.**

GMC plans are encouraged to contract with traditional and safety net providers and they must maintain standards for inclusion and ongoing participation of these types of providers. GMC plans are required to ensure

that these providers are proportionately included in the assignment process for members who do not voluntarily select a primary care physician.

1. Monitoring Default Rates:

   The default rates are monitored through a reporting process. The HCO Section receives daily, weekly and monthly reports from the enrollment broker that are required for monitoring the default process. The reports are as follows:

   - **Review the Daily Status Report- provides a breakout of enrollment into the local initiative and the commercial plans in each Managed Care county and the default ratios for each county.**
   - **Review the Monthly Managed Care Maximum Enrollment Report – provides information on the maximum and minimum beneficiary enrollment capitations of all local initiatives and commercial managed care plans.**
   - **Review the Monthly Enrollment Default Percentages Report – provides county specific default percentages for all managed care counties.**
   - **Review the MSC-B-M02 Monthly Enrollment summary – provides formula determined default percentage rates for the 2-Plan and GMC.**
   - **Review the Monthly Progress Report – provides summary for the MSM-B-M22 Monthly Cumulative Medical Beneficiaries Assigned to Local Initiative and Commercial Plans.**
   - **Random sampling of the processed enrollment forms.**

   The default rates are monitored daily and determined on a monthly basis for plan accuracy.

6. Covered Services

   All services included in the approved California Medicaid state plan are provided by the MCOs under this State Plan Amendment, with the following exceptions:

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A. Services for major organ transplant procedures that are Medi-Cal benefits (except for kidney transplant).

B. Long Term care services in a facility for longer than the month of admission plus one month.

C. Home and Community Based Services (HCBS) Waiver Programs authorized under section 1915 (c) of the Social Security Act, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver.

D. Services authorized by the California Children Services (CCS) program.

E. Mental health services which are outside the scope of PCPs except in the cases of Kaiser and Western Health Advantage MCOs in Sacramento County. Kaiser is responsible for all mental health services (including inpatient and outpatient specialty mental health services) and Western Health Advantage is responsible for all outpatient mental health services.

F. Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider, with the exceptions listed above for Kaiser and Western Health Advantage MCOs in Sacramento County.

G. Alcohol and drug treatment services and outpatient heroin detoxification.

H. Fabrication of optical lenses provided through Prison Industry Authority optical laboratories.

I. Directly observed therapy for treatment of tuberculosis provided by local health departments.

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J. Dental services as specified in CCR, Title 22, Section 51307 and EPSDT supplemental dental services as described in CCR, Title 22, Section 51340.1(a). However, Contractor is responsible for all Covered Services that are within the scope of the PCP regarding dental services.

K. Acupuncture services as specified in CCR, Title 22, Section 51308.5.

L. Chiropractic services as specified in CCR, Title 22, Section 51308.

M. Prayer or spiritual healing as specified in CCR, Title 22, Section 51312.

N. Local Education Agency (LEA) assessment services as specified in CCR, Title 22, Section 51360(b)(1) provided to a member who qualifies for LEA services based on CCR, Title 22, Section 51190.1(a).

O. Any LEA services as specified in CCR, Title 22, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq., or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in CCR, Title 22, Section 51360.

P. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHS.

Q. Adult Day Health Care.

R. Pediatric Day Health Care.

S. Personal Care Services.

T. State supported Services.

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U. Targeted case management services as specified in CCR, Title 22, Sections 51185(h) and 51351. Except that the MCO shall be responsible for: 1) coordinating health care with the TCM provider and for determining medical necessity of diagnostic and treatment services recommended by the TCM provider, and 2) ensuring access to services comparable to EPSDT TCM services for those members under age 21 who are not accepted for TCM services.

V. Childhood lead poisoning case management provided by County health departments.

W. Specific Psychotherapeutic drugs and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997.

X. Specific Human Immunodeficiency Virus (HIV) and AIDS drugs and HIV/AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, and any future new category of drugs for the treatment of HIV and AIDS, not previously classified (i.e. Fusion Inhibitors) approved by the federal Food and Drug Administration (FDA) after July 1, 1997. Effective May 1, 2004, these drugs will be carved back into the covered services for each plan.